3-29-2018

Transition of a Patient with Diabetes from Hospital to Home

Jennifer L. Henry

Transition of a Patient with Diabetes from Hospital to Home

Jennifer L. Henry

University of North Dakota

PERMISSION

Title

Department Nursing

Degree Master of Science

In presenting this independent study in partial fulfillment of the requirements for a graduate degree from the University of North Dakota, I agree that the College of Nursing of this University shall make it freely available for inspection. I further agree that permission for extensive copying or electronic access for scholarly purposes may be granted by the professor who supervised my independent study work or, in her absence, by the chairperson of the department or the dean of the Graduate School. It is understood that any copying or publication or other use of this independent study or part thereof for financial gain shall not be allowed without my written permission. It is also understood that due recognition shall be given to me and to the University of North Dakota in any scholarly use which may be made of any material in my independent study.

Signature Jennifer L. Henry

Date March 18, 2018

Abstract

When health care systems employ transitional care interventions, this leads to better patient care and reduced hospital readmissions. Hospital readmissions unnecessarily increase health care costs. Recent healthcare reform encourages improved methods to streamline the transition from hospital to home for patients with the goal of reducing rehospitalizations. Many hospitalized patients have chronic diseases that further complicate the discharge process, and diabetes is one of the most prevalent of these chronic diseases. A case study involving a patient with diabetes and her hospital discharge experience is examined, as well as a discussion of how this experience would have differed in a system with transitional interventions. A literature review of the development, interventions, and outcomes of transitional care are presented, along with information supporting transitional care programs for patients with diabetes. Ultimately, the implementation of an APRN led transitional care program can reduce unnecessary hospital readmissions, save health care dollars, and improve patient outcomes.

Transition of a Patient with Diabetes from Hospital to Home

Background

The elderly population is growing in the United States, and so is the percentage of Americans with chronic diseases such as diabetes. Health care has both quality and cost issues, which are further challenged by the increasing number of people with long-term conditions (Mitri & Gabbay, 2016). A national focus to avoid hospital readmissions has developed in the United States with intentions to reduce health care expenses.

In the past, hospitals were fee-for service, and there was little incentive for hospitals to focus on avoiding readmissions. Now, modern health care is evaluated based on quality scores, which can include avoiding 30-day readmissions. In fact, according to Mitri and Gabbay (2016), the goal is to have almost all fee-for-payments tied to quality. Health care organizations need to develop new policies and procedures regarding patient care to survive financially, with a goal to reduce health care costs by improving patient care (Mitri & Gabbay, 2016).

Effective transition of care has been identified as an important component to improve the discharge process, bolster outpatient support, and decrease hospital readmissions. Numerous programs have been developed to address the problem of rehospitalization. Many are showing early success in improving the rate of hospital readmissions while concurrently improving patient care. Additionally, APRNs with their backgrounds in holistic care are ideal leaders for transitional care programs (Hirschman, Shaid, McCauley, Pauly, & Naylor, 2015).

Readmissions occur more frequently in patients with diabetes (LaManna, Bushy, Norris, & Chase, 2015). The case study patient, Jane, is a patient with type II diabetes who experienced a hospital stay for hyperglycemia. Jane had some challenges during and after her hospital discharge, which ultimately led to her being readmitted to the hospital. In the conclusion of this

paper, the effect of an APRN led transitional care program upon Jane's discharge and follow up care is explored. Incorporating transitional care support for patients not only leads to decreased readmissions to the hospital, but also improves patients' health outcomes.

Case Report

Jane is a 66-year-old Caucasian female who presented to her primary care provider for a hospital follow up visit. There was no discharge summary available for this appointment. Jane was hospitalized with hyperglycemia, and her clinic appointment was 8 weeks post discharge. Three years ago, Jane was diagnosed with type II diabetes, and she was started on Glucophage at that time. She had not been seen in the clinic or had recommended lab work drawn since that time. For one year Jane took Glucophage, and then quit when her refills ran out. At hospital discharge, Jane was instructed to start taking "insulin shots," but her insurance would not cover the cost of the insulin prescribed to her. Because Jane did not feel that she could afford to pay out of pocket for her medication, she opted to wait until her appointment with her primary care provider to discuss switching to a more affordable medication. Because she did not feel comfortable using the glucometer given to her while in the hospital, Jane did not check her blood sugar. She also complained of feeling generalized weakness and lack of ambition. Since she was last seen in the clinic three years ago, Jane had gained twenty pounds, which she attributed to retiring from teaching almost two years ago. She did not exercise, and her favorite activities were reading and watching old movies on television.

Jane had a past medical history of type II diabetes, hypertension, and hyperlipidemia. She had had no surgeries. She was taking the following medications: lisinopril 20 mg daily, atorvastatin 20 mg daily, aspirin 81 mg daily, and a multivitamin. She was allergic to penicillin, which caused a rash. Jane had not had a pneumococcal vaccination, but she was current with all

other vaccinations. She was due for a colonoscopy but was up to date with all other recommended health maintenance. Jane did not smoke, drink alcohol, or use illicit drugs. She was sexually active with her husband.

Jane had a family history of coronary artery disease with bypass grafting (father, mother, and brother), type II diabetes (father and brother), and colon cancer (maternal grandfather and maternal uncle).

Review of Systems

Positive for **weakness** and **fatigue**. Jane denied fever, chills, or night sweats. She denied double or blurry vision. She had a diabetic eye exam about four months ago. Jane denied shortness of breath, cough, chest discomfort, or palpitations. She was positive for **polydipsia** and **polyuria**. Jane denied nausea, vomiting, abdominal discomfort, constipation, or diarrhea. She denied joint pain or swelling but was positive for **numbness in her left great toe**. She denied sensations of lightheadedness or dizziness. Jane denied any concerns with feeling depressed or anxious.

Physical Exam

Blood pressure 148/98, pulse 80, temperature 98.6, respirations 20, height 60 inches, weight 160 pounds, BMI 31.2 (obese). Labs were drawn the morning of this clinic visit after fasting for 8 hours: Hgb A1c 7.8, cholesterol 220, Triglycerides 186, HDL 36, and LDL 110. A comprehensive metabolic panel was also completed with normal results. Patient was alert, well dressed, cooperative and talkative. She was wearing glasses, pupils were equal and reactive to light and accommodation, fundi clear, no arteriolovenous nicking, no retinopathy. Neck was supple, and thyroid nonpalpable. Lungs were clear to auscultation. Heart had regular rate and rhythm, S1 and S2 present, without murmurs, clicks, gallops, or extra heart sounds. Abdomen

soft, nontender to palpation, with bowel sounds present in all four quadrants. There were no carotid bruits. Femoral, popliteal, and dorsalis pedis pulses were 2+ bilaterally. No edema was present in extremities. Monofilament felt in all areas of bilateral feet, with exception of left great toe. Patient was alert and oriented to person, place, and time.

Assessment and Plan

- **Uncontrolled Type II Diabetes Mellitus with Neurological Manifestations [E11.49]**: The American Diabetes Association recommends Jane have an A1c of 6.5 or less, so will had her take Glucophage 500 mg twice a day with food with gradual titration to 1,000 mg twice a day ("Glycemic Targets," 2018). Instructed her to check fasting blood sugar twice a day, prior to breakfast and the evening meal. Ordered a referral to both the diabetic educator and nutritionist in the next month. Will have patient return to clinic in three months with A1c drawn prior to appointment.
- **Essential Hypertension [I10]**: Current American Heart Association guidelines recommend that Jane's blood pressure be 130/80 or less, so had patient increase Lisinopril to 40 mg daily (Cifu & Davis, 2017). Recommended she check blood pressure and pulse daily and bring a record of these readings to the next appointment.
- **Mixed Hyperlipidemia [E78.2]**: According to the ACC/AHA ASCVD Risk Calculator, Jane's 10-year risk of heart disease or stroke was 24.2%, so she should be prescribed a high intensity statin ("ACA/AHA ASCVD Risk Calculator," 2017). Jane was already taking Atorvastatin 20 mg daily, so this was increased to 40 mg daily.

- **Diabetic Peripheral Neuropathy [E11.42]**: Educated Jane about the importance of keeping feet clean and dry, daily foot checks, to not go bare foot, and to wear supportive shoes.
- **Obesity with BMI over 30 [Z68.30]**: Jane was encouraged to start an exercise program. A referral was placed with the nutritionist to develop a meal plan that helps Jane both reduce her blood sugar and lose weight.
- Finally, a colonoscopy was scheduled, and patient will received a 13-valent pneumococcal conjugate vaccine prior to leaving the clinic.

The clinic visit was complicated due to the lack of a discharge summary, and the provider was unable to determine the discharge plan of care. The provider also did not have access to test results from the hospitalization. The patient was frustrated because she felt this information should have been communicated to her primary care provider. The appointment felt rushed to Jane, and she did not have time to have all her medical questions answered. She was told to see the diabetic educator for instructions on how to use her glucometer, but she could not get an appointment with the diabetic educator for another month. She went to the pharmacy to pick up a refill of testing strips and found out the brand was not covered by her insurance. Jane felt annoyed and decided to give up on checking her blood sugar. One week later, Jane was readmitted to the hospital with hyperglycemia.

Literature Review

Gaps in care during a patient's transition from hospital to home can lead to rehospitalization, and an APRN led transitional care clinic (TCC) can help close these gaps, provide better patient care, and prevent additional hospitalizations. As the elderly population continues to boom, the number of people with chronic diseases such as diabetes also increases.

To effectively care for patients with chronic and complex health conditions during transition from hospital to home, health care facilities must have transition of care interventions in place to avoid hospital readmissions.

Successful transitional care programs bridge the gap between the inpatient and outpatient setting. Myers, Garnica, and Ling (2018) define transition of care "as the movement of patients between health care locations, providers, or different levels of care within the same locations, as their conditions and care needs change" (p. e155). Times of transition are high risk times for patients, especially for patients with chronic diseases such as diabetes. Lack of communication, collaboration, medication reconciliation and follow up can all lead to poor outcomes for patients. A TCC led by an APRN can close these gaps in care by helping patients navigate the health care system, providing education and clarifying discharge instructions, and performing thorough medication reconciliation (Richardson, 2017).

Healthcare Reform to Reduce Hospital Readmissions

Due to changing reimbursement requirements, hospitals are focusing on readmission rates. "Historically, nearly 20% of all Medicare discharges had a readmission within 30 days" (McIlvennan, Eapen, & Allen, 2015, p. 17). Furthermore, Chen, Radhakrishnan, Suzuki, & Homan (2015) estimate that 1 in 3 hospital readmissions could have been prevented. In 2012, the Affordable Care Act created the Hospital Readmission Reduction Program to encourage hospitals to avoid rehospitalization, or face financial penalties (McIlvennan, et al., 2015). Now that hospitals have financial incentives for preventing readmissions, they are developing programs that can streamline the transition from hospital to home. Additionally, Accountable Care Organizations can participate in the Medicare Shared Savings Program which promotes care coordination and other components that affect readmission rates (McIlvennan, et al., 2015).

Furthermore, in July 2014, the Centers for Medicare and Medicaid Services added unplanned readmissions to quality reporting measures (McIlvennan, et al., 2015). Finally, two new current procedural terminology (CPT) codes were enacted in January 2013 to provide reimbursement for outpatient care provided during transition from hospital to home (McIlvennan, et al., 2015). The development of the Hospital Readmission Reduction Program, Accountable Care Organizations, Medicare Shared Savings Program, and reimbursement codes all provide financial incentives for health care organizations to develop programs that support patients during and after the hospital discharge.

Unnecessary hospital readmissions contribute to wasteful medical spending. According to Garnica (2017) "poor care coordination was responsible for $25 to $45 billion in wasteful spending in 2011 through avoidable complications and unnecessary hospital readmissions" (p. 263). Alper, O'Malley, and Greenwald (2017) report that avoiding readmissions to the hospital alone could save the United States 15 to 20 billion dollars a year. In fact, McIlvennan et al. (2015) report that a 10% reduction in the readmission rate could save Medicare $1 billion. If healthcare facilities are not paying attention to transitions of care, it is an omission that is costly to patients, health care facilities, and the nation.

Diabetes and Health Care Outcomes

Diabetes is a chronic disease that has a significant effect on health care expenses in the United States. "According to the American Diabetes Association, patients with diabetes have average medical expenses approximately 2.3 times higher than patients without the disease" (Hellquist, Bradley, Grambart, Kapustin, 2012, p. 43). If current trends continue, more than one third of Americans will have diabetes by 2050 (Hellquist, et al., 2012). Patients with diabetes have a three times increased chance of hospital admission when compared to patients without

diabetes, therefore care coordination must be provided for patients with diabetes to improve patient outcomes and reduce costs (Garnica, 2017). The number of people with diabetes in the hospital is also increasing. Hirschman and Bixby (2014) found that "22% of all inpatient hospitalization days were incurred by people with diabetes" (p. 192). Garnica (2017) reports that "from 1988 to 2009, the number of hospital discharges with diabetes as any listed diagnosis increased from 2.8 million to nearly 5.5 million" (p. 263). The high number of patients with diabetes makes it essential that they are included in transitional care programs when hospitalized.

Mitri and Gabbay (2016) further point out that diabetes is a major cause of increased health care costs. The authors suggest that population health management can both reduce health care costs and improve the care of patients with diabetes (Mitri & Gabbay, 2016). Population health is described as "an approach to medicine that improves patient access to care and helps patients to navigate the complex health care system" (Mitri & Gabbay, 2016, p. 935). Mitri and Gabbay (2016) state that "the health care system is fragmented and poorly designed to coordinate care management for chronic diseases" (p. 934). This fragmented and poorly coordinated care for patients with diabetes can be further compounded when the patient with diabetes is hospitalized, therefore, interventions to support patients after discharge are especially important for patients with chronic diseases such as diabetes.

Transitional care programs can have a positive impact for patients with diabetes. Hirschman and Bixby (2014) found success in a transitional care model in which an APRN meets with a patient beginning within 24 hours of admission and continues to work closely with the patient for up to two months post discharge. The APRN also works closely with numerous people on the health care team, including family caregivers and social workers. Additionally, the APRN focuses "on developing a patient- and family-centered plan of care, educating and training

of patients and their caregivers to self-manage complex care needs, interrupting health status and quality of health decline, and disrupting patterns of frequent hospital and emergency department visits" (Hirschman & Bixby, 2014, p. 193). The transitional care model also provides phone support 24 hours a day, seven days a week (Hirschman & Bixby, 2014). In conclusion, the authors reported that the transitional care model pilot significantly reduced hospital readmissions for a cost savings of $5,000 per patient (Hirschman & Bixby, 2014).

Transitional Care Programs

Additional evidence demonstrated that transition programs are reducing hospital readmissions. "According to recently released Health and Human Services data, from 2007-2011 the all-cause 30-day readmission rate among Medicare beneficiaries held relatively constant at 19.0-19.5%; in 2012 and 2013 this rate fell to 18.5% and 17.5% respectively" (McIlvennan, et al., 2015, p. 4). This indicated that between January 2012 and December 2013 there were 150,000 fewer patients readmitted to the hospital (McIlvennan, et al., 2015). Furthermore, a systematic review of transitional care interventions completed by Branowicki et al. (2017) found that post-discharge interventions, especially home visits and phone calls, reduced the incidence of hospital readmissions. Hirschman et al. (2015) also reported that "all-cause 30-day rehospitalization rates for Medicare beneficiaries decreased from an average of 19% to below 18%, at least in part due to major changes in incentives" (p. 1). Hospital readmissions are being reduced by transitional care programs.

The Veterans Administration is also striving to reduce readmissions. Brumm, Theisen, and Falciglia (2016) found favorable outcomes in a quality improvement pilot study involving Veterans with diabetes receiving transition care from hospital to home. They established that the 30-day readmission rate for patients who received transition care was less when compared to

patients who did not receive transition care. This pilot was developed in response to the Affordable Care Act, which mandated transitional care (Brumm, Theisen, & Falciglia, 2016). The goal of the pilot was "to improve transitions of care from the inpatient hospital setting to other care settings, to improve quality of care, to reduce readmissions for high-risk patients, and to document measurable savings to the Medicare program" (Brumm, et al., 2016, p. 347). By incorporating a transitional care program, the Veterans Administration reduced hospital readmissions.

A meta-analysis of transitional care programs showed further evidence in favor of transitional care programs reducing readmissions. Hirschman et al. (2015) found that a transitional care model in three randomized clinical trials led to fewer all-cause rehospitalizations at one-year post discharge, with an estimated savings of $4,845 per patient. Not only did the transitional care model reduce 30-day readmissions, but also reduce readmissions for one-year post discharge. These studies proved that transitional interventions can reduce hospital readmissions.

Transitional Care Interventions

There are a variety of different transition interventions that can improve the discharge process for patients and help avoid the patient from being readmitted. Studies reveal that important factors to consider are optimal patient education, provider collaboration, and timely hospital follow up visits. A transitional care program led by an APRN can include all these components successfully. While such a program could also be led by a physician, APRNs have training in holistic care and are often well-trusted by patients. Hirschman et al. (2015) explained this by stating, "APRNs provide patient-centered, comprehensive, holistic care that is culturally sensitive to the individualized needs of patients and their caregivers" (p. 4). To provide optimal

patient care, it is important for the provider to focus not only on the disease present, but the individual patient, and all the factors that influence the patient and disease prognosis, which APRNs have the training to do effectively.

One common theme found in the literature is the importance of early patient education by the transitional care APRN during the patient's hospitalization. While modern hospitalized patients are sicker than in the past, the hospital stay may be shorter. This leads to fewer opportunities for hospital staff to provide education for patients. "Shorter inpatient stays and financial challenges have condensed the time and resources available for nurses and other hospital personnel to prepare patients and caregivers for transitioning home" (Branowicki, et al., 2017, p. 354). A transitional care APRN can provide education that the patient and caregiver need prior to discharge from the hospital.

By following patients while they are hospitalized, the APRN can also collaborate with hospitalists and consulting providers. This collaboration can provide the APRN with information regarding the patient's hospital course, leading to more effective hospital follow up visits. The trend of hospitalists caring for inpatients has created increased challenges in the transition from hospital to outpatient care. In many cases, there is no communication between hospitalists and primary care providers (Brown & Bussell, 2011). Through Brown and Bussell's research, they found a concerning statistic that fewer than 34% of discharge summaries are available for the first hospital follow up clinic visit (Brown & Bussell, 2011). Additionally, Garnica (2017) found that providers identified lack of hospital records as the most common barrier to transitional care. Alper et al. (2017) also reported that the discharge summary is available for less than 34 percent of hospital follow up visits, and even when discharge summaries were present they often omitted important information. Not having a detailed discharge summary makes it very challenging to

provide accurate medication reconciliation, perform needed follow up tests, or ensure that the patient understands any new diagnoses—and the lack of any one of these subjects can increase a patient's chance for hospital readmission. While having the APRN follow the patient in the hospital may not affect the availability to a discharge summary the APRN would have firsthand knowledge of the patient, which can promote an effective and thorough outpatient visit.

Timely hospital follow up appointments have additionally been identified as an important component to avoiding readmissions. Only half of Medicare patients who were readmitted to the hospital within 30 days had seen a provider for a hospital follow up visit (Alper, et al., 2017). The shortage of primary care providers can make it a challenge for patients to obtain hospital follow up appointments. Garnica (2017) identified "issues obtaining a post discharge appointment, unable to get follow up appointments in a timely manner or getting diabetes follow up appointments for patients without primary care providers" (p. 266) as common barriers to transitional care. Alper, O'Malley, and Greenwald (2017) also recognized absent or delayed follow up after hospital discharge as a factor contributing to readmission to the hospital. A transitional care clinic with appointment slots dedicated to patients needing hospital follow up visits can allow patients to be seen timelier after discharge, decreasing the chance for readmission.

Conclusion

Transitional care programs reduce hospital readmissions and provide better patient care. The growing population and increasing incidence of chronic diseases such as diabetes create a challenge for health care industries to limit spending, but health care reform is providing financial incentives for reducing readmissions to the hospital. Several transitional interventions exist, and health care organizations can avoid hospital readmissions by incorporating APRN led

transitional care programs into their discharge process. By focusing on better patient care, hospital readmissions can be reduced.

A health care system that had discharge protocols in place for a seamless transition from hospital to home could have improved Jane's experience, helped prevent her readmission, and saved health care dollars. The following is a brief version of Jane's case study with transition interventions in place. Within 24 hours of admission to the hospital, Jane was visited by an APRN. Her educational needs were evaluated. The hospital diabetic educator was consulted to assist Jane with learning how to use a glucometer and provide information about insulin. The hospital dietician was consulted to help Jane improve her diet choices to reduce her blood sugar and lose weight. When discharged, Jane was sent home with a print out of detailed discharge instructions. Within two days of discharge, Jane was contacted by a Registered Nurse (RN) via phone. Jane was still not confident using her glucometer and informed the RN she was unable to afford her insulin. The RN contacted the Transitional Care APRN, who prescribed insulin covered by Jane's insurance. The community paramedic made a home visit to Jane's home the next day to answer questions and provide hands-on education using the teach-back method. On post-hospital day number 7, Jane was seen by the APRN in the Transitions of Care (TOC) Clinic. The APRN had a detailed discharge summary available prior to the appointment. Jane brought in a list of her blood sugar readings, which she had been checking three times a day. She was using her insulin as instructed. Because Jane had done so well the previous week with diet and exercise, her blood sugar readings indicated that she was able to stop insulin injections and go back to managing her diabetes with Glucophage. The APRN completed a thorough medication reconciliation and answered all of Jane's questions. The appointment was not rushed, as the TOC Clinic appointment was 45 minutes in length. After the TOC appointment, the APRN had Jane

schedule appointments with a dietician, diabetic educator, and Jane's primary care provider. All appointments occurred within the following 6 weeks.

Over the next year, Jane had no hospital admissions. She lost twenty pounds, and her A1c went down to 6.0. She no longer complained of feeling weak, and her new favorite activity was a daily walk with her new dog.

\

Learning Points

- Hospital readmissions increase healthcare costs.
- Health care reform provides incentives for hospitals to avoid hospital readmissions.
- A transitional care program led by an APRN can help reduce hospital readmissions.
- Providing better care for patients, especially patients with diabetes, can reduce healthcare costs by preventing readmissions.

References

ACC/AHA ASCVD Risk Calculator. (n.d.). Retrieve from http://www.cvriskcalculator.com/

Alper, E., MD, O'Malley, T., MD, & Greenwald, J., MD. (2017, December 19). Hospital discharge and readmission. Retrieved from https://www.uptodate.com/contents/hospital-discharge-and-readmission.

Branowicki, P. M., Vessey, J. A., Graham, D. A., Mccabe, M. A., Clapp, A. L., Blaine, K., . . . Berry, J. G. (2017). Meta-analysis of clinical trials that evaluate the effectiveness of hospital-initiated post discharge interventions on hospital readmission. *Journal for Healthcare Quality,39*(6), 354-366. doi:10.1097/jhq.0000000000000057

Brown, M. T., & Bussell, J. K. (2011). Medication adherence: WHO cares? *SciVee,86*(4), 304-314. doi:10.4016/27949.01

Brumm, S., MSN, Theisen, K., MSN, & Falciglia, M., MD. (2016). Diabetes transition care from an inpatient to outpatient setting in a veteran population. *The Diabetes Educator,42*(3), 346-353. doi:10.1177/0145721716642020

Chen, H., Radhakrishnan, K., Suzuki, S., & Homan, S. (2015). Improving diabetic patient transition to home healthcare: Leading risk factors for 30-day readmission. Retrieved from http://www.ajmc.com/journals/issue/2015/2015-vol21-n6/improving-diabetic-patient-transition-to-home-healthcare-leading-risk-factors-for-30-day-readmission

Cifu, A., MD, & Davis, A., MD. (2017). The 2017 guideline on management of high blood pressure in adults. Retrieved from https://jamanetwork.com/journals/jama/fullarticle/2664350

Garnica, P. (2017). Transition of care for patients with diabetes. *Current Diabetes Reviews,13*(3), 263-279. doi:10.2174/1573399813666161123104407

Glycemic targets: Standards of medical care in diabetes--2018. (2018). Retrieved from http://care.diabetesjournals.org/content/41/Supplement_1/S55

Hellquist, K., Bradley, R., Grambart, S., Kapustin, J., & Loch, J. (2012). Collaborative practice benefits patients: An examination of interprofessional approaches to diabetes care. *Health and Interprofessional Practice,1*(2), 43-48. doi:10.7772/2159-1253.1017

Hirschman, K., Shaid, E., McCauley, K., Pauly, M., & Naylor, M. (2015). Continuity of care: The transitional care model. *OJIN: The Online Journal of Issues in Nursing,20*(3). doi:10.3912/OJIN.Vol20No03Man01

Hirschman, K. B., & Bixby, M. B. (2014). Transitions in care from the hospital to home for patients with diabetes. *Diabetes Spectrum,27*(3), 192-195. doi:10.2337/diaspect.27.3.192

LaManna, J. B., PhD, Bushy, A., PhD, Norris, A. E., PhD, & Chase, S. K., EdD. (2015). Early and intermediate hospital-to-home transition outcomes of older adults diagnosed with diabetes. *The Diabetes Educator,42*(1), 72-86. doi:10.1177/0145721715620020

McIlvennan, C. K., DNP, Eapen, Z. J., MD, & Allen, L. A., MD. (2015). Hospital readmissions reduction program. *Circulation,131*(20), 1796-1803. doi:10.1161/circulationaha.114.010270

Mitri, J., & Gabbay, R. (2016). Understanding population health through diabetes population management. *Endocrinology and Metabolism Clinics of North America,45*(4), 933-942. doi:10.1016/j.ecl.2016.06.006

Myers, A., Garnica, P., & Ling, J. (2018). Advances in managing type 2 diabetes in the elderly. *American Journal of Therapeutics,25*(1), E152-E172. doi:10.1097/mjt.0000000000000667

Richardson, B. M. (2017). An innovative transitional care program improves community health. *JONA: The Journal of Nursing Administration,47*(7/8), 357-358. doi:10.1097/nna.0000000000000493